New Hampshire Retirement System, 4 Chenell Drive, Concord, NH 03301-8509, (603) 271-3351

EMPLOYER'S STATEMENT OF ORDINARY DISABILITY

_____Ordinary Disability **_____Accidental Disability**

INSTRUCTIONS

The employee identified below has filed a claim for disability benefits from the New Hampshire Retirement System. The Employee's Statement of Disability is attached for your review. Please complete this form and return it to the New Hampshire Retirement System.

EMPLOYER INFORMATION

_____ _____ _____

(Name) *(Address)* *(Date)*

APPLICANT INFORMATION

_____ _____ _____

(Name) *(SS Number)* *(Occupation)*

INCAPACITY INFORMATION

- To the best of your knowledge what is the nature of the applicant's incapacity? _____
  _____
- Date of onset of disability (illness, condition or injury) _____
- Are there any duties that this employee is required to perform that are not specifically identified in the job description? _____Yes/No Please identify under comments on the reverse side of this form.
- Have the duties, or has the working environment, been modified to accommodate the employee in the position from which he/she is seeking disability retirement? _____ Yes/No Please specify under comments on the reverse side of this form.
- Can the duties or working environment be modified to accommodate the employee in the position from which he/she is seeking disability retirement? _____ Yes/No Please specify under comments on the reverse side of this form.
- Has a Worker's Compensation claim been filed for the incapacity claimed to be disabling? _____ Yes/No
- Is the applicant in receipt of workers' compensation? _____ Yes/No If yes, date payments commenced_____/____/____
  Month Day Year

Any additional comments may be noted on the reverse side of this form.

SUPPORTING DOCUMENTATION

Please provide copies of the following documents to the NHRS:

1. Any medical reports which relate to the incapacity for which the applicant is claiming disability retirement.
2. A current job description and a job description at the time of incapacity if they are not one and the same. For state employees, a supplemental job description is required.
3. Witness statement(s) and employer records pertaining to any work-related incapacity.
4. State of NH Department of Labor Employer's First Report of Injury (Form 8 WC), if applicable.
5. State of NH Department of Labor Memo of Payment of Disability Compensation (Form 9WCA), if applicable.
6. Any other pertinent information you may wish to submit.

A copy of this document and any other information submitted by the employer will be provided to the employee claiming disability.

OVER

CERTIFICATION

We certify that the injury information provided above and the attached supporting documentation are true and accurate to the best of our knowledge.

(Signature of Immediate Supervisor)	*(Date)*	*(Signature of Highest Departmental Authority)*	*(Date)*
(Name Printed)	*(Title)*	*(Name Printed)*	*(Title)*

Comments: